CareFirst BlueChoice

CareFirst BlueCross BlueShield

Harford County Governmental Entities

Health Benefit Options

2007

BlueChoice HMO

BlueChoice HMO, from CareFirst BlueChoice, Inc.(CareFirst BlueChoice), aims to keep you healthy by emphasizing prevention, early detection and early treatment. That's one of the main advantages of your BlueChoice HMO coverage. We work with you to help prevent illness and we encourage you to seek care when it is needed.

Coverage When You Travel

Out-of-area coverage is limited to emergency care only. However, members and dependents who plan to be out of the BlueChoice HMO service area for at least 90 consecutive days can take advantage of the Away from Home Care® Program, which allows temporary benefits through another Blue Cross and Blue Shield affiliated HMO. This special plan provides coverage for routine services and is perfect for extended out-of-town business or travel, semesters at school or families living apart. For more information on Away from Home Care®, call Member Services at (866) 520-6099.

Your Primary Care Physician

For members with MPOS and BlueChoice

Establishing a relationship with one doctor is the best way for you to receive consistent, quality health care; therefore, you must select a primary care physician (PCP) at the time of your enrollment into MPOS or BlueChoice.

Your PCP will:

- provide basic medical care – treat illnesses and provide preventive care,
- prescribe any medications that you may require,
- maintain your medical history,
- work with you to determine when you should see a specialist, assist in the selection of a specialist, and provide you with a written referral when needed.

Referrals to Specialists

For members with MPOS and BlueChoice

Your PCP will coordinate your medical care and provide treatment for a variety of medical conditions. Generally, your PCP will need to see you for a proper evaluation before issuing a written referral. You and your PCP can work together to select a specialist.

The Three-Tier Prescription Drug Program

This prescription drug program is offered as part of your health care benefits. The plan is administered through Argus. This program covers both non-maintenance and maintenance prescription drugs dispensed by a retail pharmacy or Walgreens mail service pharmacy. This program is based on the CareFirst and CareFirst BlueChoice preferred drug list, called a Formulary, which is a list of certain brand-name prescription drugs and all generic prescription drugs used by participating physicians when writing prescriptions. Your participating physician has a complete copy of the CareFirst and CareFirst BlueChoice preferred drug list. A copy can also be found on our web site at **www.carefirst.com.**

Tier 1:
Generics

- Copays for generic drugs are the lowest. All generic drugs are on the preferred drug list and available at this copay.

Tier 2:
Preferred brand-name drugs

- Copays for preferred brand-name drugs are higher than generic drugs.
- When a generic version of a preferred brand-name drug becomes available, the brand-name version moves from Tier 2 to Tier 3 (non-preferred brand-name drugs).

Tier 3:
Non-preferred brand-name drugs

- Copays for non-preferred drugs are the highest.
- If your brand-name drug has a generic equivalent, the brand-name drug will not be on the preferred drug list and will be a Tier 3 drug.
- You will pay the lowest copay (Tier 1) if you choose the generic version of the drug, or the highest copay (Tier 3) if you choose the brand-name version of the drug.

PPO Plan

Choosing a doctor is an important, personal decision. By selecting CareFirst BlueCross BlueShield's (CareFirst) Preferred Provider Organization (PPO) plan, you are ensuring your freedom to choose your own doctor or specialist, every time you need care.

Depending on the physician you choose for your care, the PPO plan offers lower copayments while providing you financial incentives for seeking your health care from our large Preferred Provider network. And best of all with the PPO plan, there's no need to select a Primary Care Physician (PCP) or to seek a referral before receiving care.

Out-of-Area Coverage

As a PPO member, you will receive a widely recognized and accepted health care identification card. So now, you can take your health care benefits with you – across the country and around the world. BlueCard® PPO, a program from the Blue Cross and Blue Shield Association, allows PPO members to receive the same type of health care benefits of their local plan while living or traveling outside of your health plan area. BlueCard® program includes over 6,100 hospitals and 600,000 providers nationally.

Maryland Point-of-Service Plan (MPOS)

Maryland Point of Service (MPOS) offers two levels of benefits in one health plan. When you need medical care, you have the flexibility to see your primary care physician (PCP) or you may go "out of the network" and see any doctor you choose. Your choice determines whether benefits will be paid at the in-network or out-of-network level.

Large Network

Doctors, specialists and hospitals are located throughout Maryland, Washington, D.C., and Northern Virginia.

No Hassle Billing

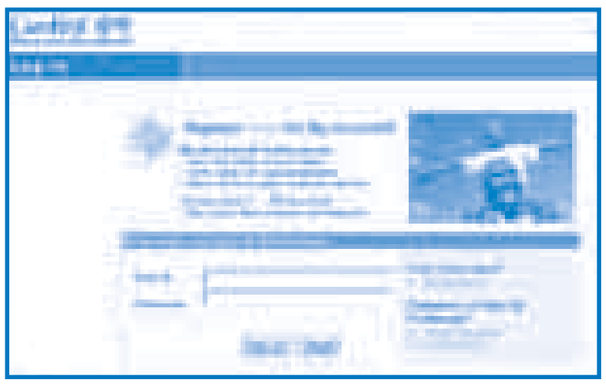
Maryland Point of Service requires little paperwork, when your PCP coordinates your care. In addition, MPOS provides direct reimbursement to your doctor, which means no hassle and no claims to file.

Out of Area Coverage

When you require health care while away from home, you will be covered with your in-network benefits for emergency care. All other services will be covered at the out-of-network benefit level.

Online Access through *My Account*

CareFirst is pleased to offer *My Account*, a web site that allows you to directly access your health benefit information online. So now, you can obtain answers to many questions regarding your health insurance coverage and costs, including your date of eligibility, who is included on your policy and the status of your current and previous claims, as well as your current deductible and maximums – all conveniently online. Visit **www.carefirst.com/myaccount** to register.



While our Member Services representatives are still here to serve you, isn't it nice to know that you can get answers to many of your questions on your time?

Health Information on the Internet

Visit our own online, interactive guide for health related topics. Called *My Care First*, this site offers information on nutrition, fitness, chronic illnesses, stress, mental health and much more. You'll also find support if you're trying to lose weight, quit smoking or manage your chronic illness. *My Care First* covers the latest developments in medicine and health. Check it out at **www.carefirst.com** to learn how you can maintain a healthier lifestyle.

Options Discount Program

As a CareFirst or CareFirst BlueChoice member, you are entitled to discounts on alternative therapies and health and wellness programs such as acupuncture, massage, chiropractic, yoga, pilates, tai chi, guided imagery, nutritional counseling, and fitness centers. The program also offers discounts on health-related magazines, Weight Watchers Online®, hearing aids, mail-order contacts and laser vision correction. Because Options is not a covered benefit to your medical plan, there are no claim forms, paperwork or referrals. Simply visit **www.carefirst.com** to learn more.

CareFirst BlueChoice

CareFirst BlueCross BlueShield

10455 Mill Run Circle
Owings Mills, Maryland 21117

www.carefirst.com

CUT6107-6N (4/07)

Harford County Governmental Entities Health Benefits Comparison Chart

July 1, 2007 – June 30, 2008

Benefit	CareFirst BlueCross BlueShield Preferred Provider Organization (PPO)		Maryland Point of Service		CareFirst BlueChoice
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	
Deductible	$250 Individual/$500 Family	$500 Individual/$1,000 Family	None	$500 Individual/$1,500 Family	N/A
Out-of-Pocket Maximum	None	$2,000 Individual/$4,000 Family	None	$2,000 Individual/$4,000 Family	N/A
PHYSICIAN SERVICES					
Surgeon	100% AB after deductible	Covered at 80% of AB after deductible	100% AB	80% AB after deductible	Covered in full inpatient, $10 Copay PCP; $20 Specialist in office (facility covered in full)
In-Hospital	100% AB after deductible	80% AB after deductible	100% AB	80% AB after deductible	Covered in full
HOSPITAL					
Hospital Room/Semi Private*	100% AB after deductible/365 days	80% AB after deductible/365 days	100% AB	80% AB after deductible	Covered in full
Outpatient Surgery**	100% AB after deductible	80% AB after deductible	100% AB	80% AB after deductible	$10 Copay PCP/$20 Specialist
Emergency Care (within 72 hours) • Facility • Facility/Practitioner • Provider's Office	 100% AB after $35 copay 100% AB after $20 copay 100% AB after $20 copay	 100% AB after $35 copay 100% AB after $20 copay 100% AB after $20 copay	 100% AB 100% AB 100% AB	 100% AB 100% AB 100% AB	 $50 Copay Emergency Room (waived if admitted) $20 Copay Urgent Care Center $10 Copay PCP/$20 Specialist
MEDICAL SERVICES					
Diagnostic X-rays	100% AB, no deductible	80% AB in office after deductible	Outpatient/Office 100% AB	Outpatient/Office 100% AB	Covered in full
Radiation & Chemotherapy	100% AB after $35 facility Copay and $20 physician Copay	80% AB after deductible	100% AB after a $25 facility Copay and $20 physician Copay	80% AB after deductible for professional/$35 facility Copay	Covered in full inpatient $20 Copay outpatient
Laboratory Tests	100% AB, no deductible	80% AB after deductible	Outpatient/Office 100% AB	Outpatient/Office 100% AB	Covered in full
Allergy Testing	100% AB after $20 Copay	80% AB after deductible	100% AB	80% AB after deductible	$10 Copay PCP/$20 Specialist
Allergy Treatment/Injections	100% AB after $20 Copay	80% AB after deductible	100% AB	80% AB after deductible	$10 Copay PCP/$20 Specialist
Physical Therapy	$20 office copay; $35 outpatient facility copay; $20 professional copay 100 visit limit	80% AB after deductible 100 visit limit per benefit period	100% AB after $15 Copay 100 visit limit	80% AB after deductible; 100 visit limit	$20 Copay up to 30 visits per condition per contract year when approved by HMO/HMO physician (PT & OT combined)
PREVENTIVE CARE					
Well Baby & Child Care	100% AB after $20 Copay (no deductible)	80% AB (waive deductible)	100% AB after $15 Copay	80% AB no deductible	$10 Copay PCP
Immunization	100% AB (no deductible)	80% AB (waive deductible)	100% AB	80% AB no deductible	$10 Copay PCP
Annual Physical Exam	One per calendar year age 18+; $20 Copay; 100% AB up to $200 maximum includes routine diagnostic tests (no deductible)	One per calendar year age 18+; 80% AB, $200 maximum includes diagnostic tests (after deductible)	100% AB after $15 Copay one per calendar year $200 maximum	80% AB after deductible	$10 Copay PCP/$20 Specialist
Annual Gynecological Exam	One per calendar year $20 Copay; 100% AB (no deductible)	One per calendar year 80% AB after deductible	One per calendar year 100% AB after $15 Copay	80% AB after deductible	$10 Copay PCP/$20 Specialist
Eye Exams	No benefit for routine exam	No benefit for routine exam	No benefit for routine exam	No benefit for routine exam	$10 Copay at Davis Vision Provider one per calendar year
Eye Glasses	No benefit	No benefit	No benefit	No benefit	Discounts available through Davis Vision
OFFICE					
Medical Visits for Illness	100% AB after $20 Copay per visit; (no deductible)	80% AB after deductible	100% AB after $15 Copay	80% AB after deductible	$10 Copay PCP/$20 Specialist
SPECIAL SERVICES					
Hearing aid evaluation test (one every 36 months)	100% AB, no deductible	80% AB after deductible	100% AB, no deductible	80% AB after deductible	$20 Copay/visit (once every year)
Hearing aids (one every 36 months)	100% AB, no deductible	80% AB after deductible	100% AB, no deductible	80% AB after deductible	Limited to maximum of $1,400 every 36 months for one hearing aid for each hearing impaired ear; under 18 only
Home Health Care Visits	90 days of unlimited visits covered at 100% AB; no deductible (approved plan treatment required)	90 days of unlimited visits covered at 100% AB; no deductible (approved plan treatment required)	100% AB; approved plan of treatment required	100% AB; approved plan of treatment required	Covered in full
Maternity Care	100% AB after deductible	80% AB after deductible	100% AB	80% AB after deductible	Hospitalization covered in full. Professional pre/post natal care $20 Copay per visit, not to exceed $200 per pregnancy
Infertility Services Artificial Insemination & In Vitro Fertilization	Not covered	Not covered	Not covered	Not covered	Counseling and testing, $20 Copay with specialists, artificial insemination covered at 50% of plan allowance; IVF covered at 50% of plan allowance - limited to 3 attempts per live birth; lifetime maximum $100,000
Ambulance (when medically necessary)	100% AB no deductible	100% AB no deductible	100% AB	100% AB	Covered in full
MENTAL HEALTH/SUBSTANCE ABUSE COMBINED					
Inpatient Care*	Inpatient Hospital: 100% AB (no deductible) Halfway House: 100% AB (no deductible)	Inpatient Hospital: 80% AB (no deductible) Halfway House: 80% AB (no deductible)	100% AB (services must be preauthorized)	80% AB after deductible (services must be preauthorized)	Inpatient: (includes Halfway House) Covered in full. Partial Hospitalization: 60 days per year, $5 Copay per day
Outpatient Care (services must be preauthorized)	Visits 1-5, 80% AB no deductible Visits 6-30, 65% AB no deductible Visits 31+, 50% AB no deductible	Visits 1-5, 80% AB after deductible Visits 6-30, 65% AB after deductible Visits 31+, 50% AB after deductible	Visits 1-5, 80% AB Visits 6-30, 65% AB Visits 31+, 50% AB	Visits 1-5, 80% AB after deductible Visits 6-30, 65% AB after deductible Visits 31+, 50% AB after deductible	Visits 1-5, 20% coinsurance Visits 6-30, 35% coinsurance Visits 31+, 50% coinsurance
PRESCRIPTION DRUG PROGRAM					
	$10 Copay - generic drugs $20 Copay - brand-name preferred drugs $35 Copay - non-preferred drugs Maintenance drugs: Retail - 3 Copays Mail Order - 2 Copays	$10 Copay - generic drugs $20 Copay - brand-name preferred drugs $35 Copay - non-preferred drugs Maintenance drugs: Retail - 3 Copays Mail Order - 2 Copays	$8 Copay - generic drugs $15 Copay - brand-name preferred drugs $30 Copay - non-preferred drugs Maintenance drugs: Retail - 3 Copays Mail Order - 2 Copays	$8 Copay - generic drugs $15 Copay - brand-name preferred drugs $30 Copay - brand-name preferred drugs Maintenance drugs: Retail - 3 Copays Mail Order - 2 Copays	$5 Copay - generic drugs $10 Copay - non-preferred drugs $25 Copay non-preferred drugs $4,000 maximum per person Maintenance drugs: Retail - 3 Copays Mail Order - 2 Copays

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AB-Allowed Benefit.
*Inpatient stays require precertification. **If the hospital bills for use of the facility or provider bills for use of his office, the member will be subject to the appropriate copays.*

Dental Options Benefits

Benefit	Regional Traditional Dental Coverage	Regional Preferred Dental In-Network	Regional Preferred Dental Out-of-Network
Class I—Diagnostic, Preventive, sealants, space maintainers	100% of AB	100% of AB	75% of AB
Class II—Fillings, periodontics (non-surgical) simple extractions	80% of AB (after deductible)	80% of AB (after deductible)	60% of AB (after deductible)
Class III—Periodontics (surgical) Endodontics, oral surgery, anesthesia	80% of AB (after deductible)	80% of AB (after deductible)	60% of AB (after deductible)
Class IV—Crowns and crown build up, dentures, bridges, inlays/onlays/veneers	50% of AB (after deductible)	50% of AB (after deductible)	35% of AB (after deductible)
Class V—Orthodontics (up to Age 19)	50% of AB	50% of AB	35% of AB
Annual Deductible Classes II, III and IV			
Individual	$ 25	$25	$ 75
Family	$ 75	$75	$150
Maximums			
Annual Maximum Classes I, II, III and IV	$1,500	$1,500 Combined In and Out-of-Network	
Lifetime Maximum Class V	$1,000	$1,000 Combined In and Out-of-Network	

AB-Allowed Benefit.

Vision Benefits

Schedule of Benefits

Benefit	In-Network Coverage[1]	Out-of-Network Coverage
Vision Exam	Covered in full	$45 Allowance
Lenses (per pair)		
Single	Covered in full	$52 Allowance
Bifocal	Covered in full	$82 Allowance
Trifocal	Covered in full	$101 Allowance
Frames		
Tower Collection Frames	Approximately 270 frames covered in full	N/A
Non Tower Frame at Independent Provider	$45 Allowance[2]	$45 Allownce
Frame at Retail Provider	$90 Allowance	$45 Allowance
Contact Lenses		
Medically Necessary Lenses	Covered in full with prior approval	$285 Allowance
Single Vision Lenses	$97 Allowance	$97 Allowance

Benefits are provided for one exam and one pair of glasses or contact lenses per year.

[1] Services must be rendered by a Davis Vision provider.
[2] Plan pays $45 allowance towards wholesale cost. If more than allowance, you pay 2 times the difference between the wholesale cost and $45 allowance (Example: Wholesale cost= $50; You pay $5x2=$10)

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Out-of-Pocket Maximum	None	$2,000 Individual/$4,000 Family	None	$2,000 Individual/$4,000 Family	N/A
PHYSICIAN SERVICES					
Surgeon	100% AB after deductible	Covered at 80% of AB after deductible	100% AB	80% AB after deductible	Covered in full inpatient, $10 Copay PCP; $20 Specialist in office (facility covered in full)
In-Hospital	100% AB after deductible	80% AB after deductible	100% AB	80% AB after deductible	Covered in full
HOSPITAL					
Hospital Room/Semi Private*	100% AB after deductible/365 days	80% AB after deductible/365 days	100% AB	80% AB after deductible	Covered in full
Outpatient Surgery**	100% AB after deductible	80% AB after deductible	100% AB	80% AB after deductible	$10 Copay PCP/$20 Specialist
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